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Common Immunity or Microbial Xenophobia? Nation-State Boundary Controls and the Spread of Disease in the Era of Covid-19

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Abstract

In the era of Covid-19, governments and commentators alike have argued that border controls are a necessary tool in the fight against disease. Indeed, for much of 2020, the Trump administration in the United States adopted an almost singular focus on limiting transnational mobility as the lynchpin of its pandemic response. Ironically, this strengthening of border controls, combined with the uninterrupted operation of immigration detention and deportation, incubated the virus and amplified its circulation in the United States and abroad. Such outcomes raise many questions. How did the policing of national borders become embraced as such a pivotal tool in the fight against disease? What work does the border accomplish vis-a-vis pandemic control? And how do these public health outcomes shed new light on the nature of border controls? In this article, we argue that the principal contribution of border controls to the unfolding of contagion emerges from their role in the differentiation and policing of unequal legal and political status. We explore how this differentiation has demonstrably come to drive patterns of risk, harm and vulnerability during the era of Covid-19. As a contrast, we also discuss various grassroots and official interventions that have instead woven relationships of solidarity, care and cooperation across differences of nationality and legal status and their associated territorial expressions. Together, we read these efforts as cultivating a kind of "common immunity," one based on a recognition of mutual interdependence that is foundational to collective life, health and wellbeing.

Keywords
Covid-19, border controls, disease, mobility, pandemic geopolitics, public health

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Introduction

A remarkable entrenchment of nation-state borders and territorial boundary controls has characterized the era of Covid-19. According to the International Organization for Migration (I.O.M.), by April 2020—roughly a month after the World Health Organization declared a global pandemic—194 countries, territories and areas worldwide had enacted 45,427 new restrictions and measures aimed at limiting transnational mobility (IOM 2020). Hence, by the second quarter of 2020, 91 percent of the world's population was living in a country that had restricted all routine international entry, and 39 percent were living in a country that had completely closed its borders to noncitizens or to non-permanent residents (Connor 2020). Meanwhile, many governments and commentators heralded the imposition of severe restrictions in countries like Australia and New Zealand (which had considerable early success in controlling the virus) as a vindication of the position that border controls are a necessary tool in the fight against disease (Boyd 2020; Quintana and Ries 2020; Pueyo 2020).

This was certainly the case in the United States (U.S.). On April 8, 2020, U.S. Attorney General William Barr argued, for example, "[a]s horrible as this is and as tragic as it is, there are a couple of good things that can flow from this experience… as much as people talk about global warming… the real threat to human beings is microbes and being able to control disease, and that starts with controlling your border" (Boboltz 2020). Having acted upon this logic, U.S. officials repeatedly asserted that enhanced border controls were instrumental to curbing and containing the pandemic. In July 2020, after reviewing a newly constructed section of border wall in Yuma, Arizona, then-President Donald Trump (2020) asserted "I built the wall, and it worked 100 percent. You know what I'm talking about… it stopped COVID; it stopped everything. It stopped the whole deal" (see also Department of Homeland Security 2020). Despite such boasts, Covid-19 cases exploded across the United States throughout 2020, 2021 and into 2022. This occurred even as the U.S. government essentially ended all non-essential, cross-border land travel to and from Canada and Mexico for 20 months, while, as of June 2022, it continued to implement extraordinary policies such as the effective abrogation of U.S. asylum law and immediate extra-judicial return to Mexico of all arriving unauthorized migrants and asylum-seekers who cross the southern U.S. boundary. Meanwhile, due to these immigration and border controls, the U.S. detention and deportation system has incubated, spread and intensified the pandemic globally.

Such less-than-successful public health outcomes raise many questions. How did the policing of nation-state borders become embraced as a pivotal tool in the fight against disease? What work did border and immigration policing accomplish to amplify or reduce the diffusion of Covid-19? And how do these public health outcomes shed new light on the nature of border controls, and on the role they play in shaping the world and the peoples and places within it? In what follows, we address these questions. Our exploration focuses on the U.S. government's policing of the boundaries of the United States and of the people within and near these territorial limits—particularly the U.S.-Mexico borderlands. Like any case study, its generalizability is limited. Still, we insist that the case of the United States speaks to assumptions, worldviews, and world-making that go far beyond the case itself.

In addressing the questions above, we argue that despite their stated purpose of limiting or regulating human mobility, the principal contribution of border controls to the unfolding of contagion emerges from their role in the simultaneous differentiation and policing of unequal legal and political status. Of course, scholars have long understood that rather than simply a spatial barrier, the border works as a sorting mechanism: its importance lies just as much in dividing persons according to the rights and freedoms they are entitled to exercise (including the freedom of relatively unencumbered transnational mobility) as it does in dividing people or territories from one another (see, for example, Mezzadra and Neilson 2013; Nevins 2008; Rumford 2008; Walters 2006; Balibar 2004; Paasi 1998). As discussed below, during the era of Covid-19, this sorting mechanism became decisive in driving identifiable patterns of risk, harm and vulnerability in the United States and around the world. Although such

outcomes were experienced unevenly across populations and space, by allowing the continuation of viral spread, they undermined public health generally. Thus, although in principle some limitations on human mobility (e.g., isolation, quarantine and social distancing) may be effective and legitimate for controlling a pandemic, we argue that nation-state border and immigration controls prove to be a generally counterproductive instrument for accomplishing this objective.

In the paper's conclusion, we first consider the government of Australia's pandemic response as a kind of a limit case for our argument. We then gesture toward a different set of possibilities reflected in how a host of official and grassroots initiatives around the world have undertaken to fight the pandemic by weaving networks and relationships of solidarity, care and cooperation that transcend territorial borders and differences of nationality and legal status. We read these interventions as cultivating a condition that Esposito (2011) describes as "common immunity," and argue that fostering this condition require a recognition of our mutual entanglement and interdependency as foundational to collective health and wellbeing. Instead of the differentiation and policing of unequal mobility and legal status, such a recognition suggests a need to embrace more open, just, and epidemiologically effective ways of responding to disease, and the cultivation of corresponding relationships across space.

Microbial Xenophobia and the Expansion of Border Controls

Scholars have long observed how an "immunitarian logic" informs the expansion of border controls (Minca 2020; Minca and Rijke 2019; Vaughan-Williams 2016; Esposito 2011). This way of conceptualizing nation-state borders analogically reads the "nation" as an organic body (consider, for example, the "body politic"), one that is essentially healthy and innocent, but continuously threatened by "alien bodies" carrying "alien contagion." Shah (2016) describes the biopolitical imaginary that emerges from this analogical paradigm as operationalizing a kind of "microbial xenophobia," and during the Covid-19 pandemic she identifies this as circulating through "the story we have been told from the beginning… one of a passive population suddenly attacked by a foreign being" (Shah 2020, 13).

These kinds of xenophobic and immunological imaginaries have a long history in the United States (see, for example, Freeman Gill 2020; Mckiernan-González 2012; Shah 2016; Molina 2011). This history is tied to assertions about who is considered fit to be a member of the national community, and of the country's workforce; as well as to notions about what it means to be a proper "American" (see Fairchild 2003). As Markel and Stern (2002) explore, the association between foreign populations and disease became particularly powerful beginning in the late 1800s, a development tied to the significant arrival of "new" immigrants from central, eastern, and southern Europe, as opposed to "older" patterns of immigration from northern and western Europe. It then found expression in a growing number of medical and health criteria (along with political affiliation) that could be used to restrict entry to the United States (a process that culminated in 1921 with the introduction of the national-origins quota system). The rise of such criteria were linked to three phenomena: 1) the emergence of the germ theory of disease, bacteriology and modern hygienic practice, which each sought to identify and prevent the spread of particular microorganisms as sources of disease; 2) the emergence of evolutionary and eugenicist thinking that categorized different racial and national populations according to traits considered to be more or less desirable; and 3) the expansion of the U.S. government's capacity to surveil public health, and a concomitant desire to construct a country free of unwanted disease. The resulting epidemiological border state disproportionately focused its efforts on the lower reaches of the United States' class- and race-based hierarchies. As such, for example, individuals of Chinese, Mexican, and Eastern European (particularly Jewish) origin and descent received disproportionate state scrutiny (Markel and Stern 2002, 760-762), while in the imaginary of the U.S. public health apparatus these populations continued to be read as "foreign" regardless of actual citizenship status, or of how long any particular group or individual had been present in the United States (see, e.g., Molina 2006).

During the early 20th century, eugenicist thinking similarly converged with medical panics along the U.S.-Mexico border to codify those defined as Mexican as racially and epidemiologically threatening. This convergence contributed to the U.S. government's first steps toward turning the international border into a heavily policed region. In a case study of the border city of El Paso, Texas, Stern (1999) identifies how, beginning in January 1917, in a context of mounting concern about typhus crossing the U.S.-Mexico divide as well as instability related to the Mexican Revolution, the U.S. Public Health Service and the Bureau of Immigration instituted a quarantine of all border crossers from Mexico. That year alone, 127,173 Mexicans were bathed and deloused at the bridge that joined the United States with Ciudad Juárez (Romo 2005: 229). This included the stripping of all Mexican nationals suspected of being "vermin infested," and the sterilization of their clothing (Stern 1999). For those suspected of lice or disease, the inspection process also involved delousing and bathing with a mixture of soap, kerosene and water. According to Romo (2005, 235), U.S. border officials targeted all immigrants from the Mexican interior, as well as "second-class" residents of Ciudad Juarez, requiring them to strip completely, turn in their clothes to be sterilized in a steam dryer and fumigated with hydrocyanic acid, and stand naked before a Customs inspector who would check his or her "hairy parts"— scalp, armpits, chest, genital area—for lice. Those found to have lice would be required to shave their heads and body hair with clippers and apply a mix of kerosene and vinegar on their body. Even though the typhus scare soon disappeared, delousing and chemical spraying continued in some U.S. border towns until the late 1950s. The fumigants employed included dichlorodiphenyltrichloroethane (DDT) and, beginning in the 1920s, Zyklon B (a variant of which Nazi Germany later deployed in the death chambers; see Romo 2005; Stern 2005; Fairchild 2003).

An epidemiological focus on the border continued during the Bracero program (1942-1964), when concerns about disease led U.S. officials to subject contract workers from Mexico to humiliating medical examinations, compelling them to undress and undergo chest x-rays, serological tests and chemical baths to limit the spread of tuberculosis and venereal disease (Molina 2011). Importantly, as Rodríguez (2013) observes, Bracero workers in California, Arizona and Texas, for example, experienced higher rates of disease when compared to the surrounding population. However, this difference was due to conditions in the farms, fields and labor camps where these workers lived and labored. These conditions included cramped living quarters, exposure to agricultural chemicals, a lack of adequate access to health care and sanitation, the provision of inadequate food and nutrition, and threats of retaliation if workers complained (Molina 2011). Yet rather than addressing such harmful working and living conditions, the United States spent decades framing disease as a racialized and foreign problem originating with the arrival of the workers themselves. As we discuss next, the contours of this history reverberate in contemporary U.S. government efforts to understand, explain and intervene against SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2, the strain of coronavirus that causes Covid-19).

Codified Inequality and the Proliferation of Covid-19

Throughout the early months of the pandemic the Trump administration and allied domestic political leaders repeatedly downplayed its seriousness (Summers 2020), while also racially and spatially displacing responsibility for the ensuing crisis. The president himself, for example, frequently insisted on referring to the disease as the "Wuhan," "Chinese" or "China" virus, and blamed the disease on the Chinese government, alleging that it had mischaracterized the virus's risk and had failed to control its spread (see, for example, Mangan 2020). Consistent with this xenophobic scapegoating, on March 20, 2020, the Trump administration invoked its emergency public health authority under USC Title 42 to enact a new policy categorically prohibiting asylum-seekers from entering the United States, charging that migrants and asylum-seekers from Latin America posed a serious risk of introducing Covid-19 to the country (Narea 2022). (As of the time of writing, despite lifting most other public health restrictions,

the Biden administration has maintained this policy - and it remains unclear whether it will be lifted any time soon). Finally, in concert with some state governors in the United States, the Trump administration cast blame for high rates of infection and continued viral spread on immigrants from Latin America—especially from Mexico. For instance, in June 2020, as Covid-19 cases exploded in Florida, Governor Ron DeSantis asserted that "the No. 1 outbreak we've seen is in agricultural communities," and blamed "overwhelmingly Hispanic" farmworkers and day laborers—despite the fact that the outbreak did not align with Florida's peak agricultural season, and that many emerging cases were from non-agricultural areas (Chang et al. 2020). In Arizona, Governor Doug Ducey also deflected responsibility for the state's spiraling caseload by blaming residents of Mexico "coming across the border for better medical care" (Diaz 2020). Meanwhile, U.S. Health and Human Services Secretary Alex Azar seized on these narratives, asking representatives of the Department of Homeland Security (DHS), "Are there any immigration patterns DHS is seeing that support the thesis that seeding could be coming from Mexicans over the border? Could we be seeing the aftereffects of cinco de mayo [sic]?" (Murphy and Stein 2020).

Like U.S. Black, Latinx and Indigenous populations as a whole, noncitizen, immigrant workers from Latin America initially contracted the virus at rates higher than those encountered among white, Anglo populations—at least during the first year of the pandemic, before the widespread availability of vaccines (see Oppel et al. 2020). In fact, during 2020, Latinxs were found to be about three times as likely to contract the virus, and once infected almost twice as likely as their white, Anglo counterparts to die as a result of infection. However, similar to those patterns observed in the last century, the primary reasons for these disparities are the precarious work and housing conditions to which marginalized and illegalized communities are disproportionately exposed, as well as the *de facto* and *de jure* exclusion of noncitizens from many of the public health measures necessary to control the virus. For example, those working in "frontline" industries like healthcare, eldercare, foodservice, manufacturing, meatpacking and agriculture—all heavily populated by people of color and immigrant workers—are generally unable to labor from home, resulting in continuous exposure to co-workers, employers, customers, and patients (Cox 2021; Macias Gil et al. 2020; McClure et al. 2020). Meanwhile, many of their workplaces failed to adequately implement distancing guidelines, to distribute personal protection equipment (PPE), or to make other operational adjustments that would have reduced workers' routine vulnerability to infection. Making matters worse, even when faced with widespread outbreak the U.S. government directly intervened to require some of these industries to continue operating. On April 28, 2020, for instance, Trump invoked the Defense Production Act to categorize meatpacking facilities as an infrastructure that is "essential" to national security (Jamieson 2020).

At the same time, a combination of low income and high housing prices forces many of these same workers to reside in cramped and crowded conditions, where large numbers of persons live together in houses and apartments with relatively small square footage. As Macias Gil et al. (2020) discuss, once a person becomes infected with SARS-CoV-2 these conditions make it very difficult for that person to effectively quarantine, allowing it to spread easily within their household. Meanwhile, in 2020, the U.S. Centers for Disease Control and Prevention (2020) warned that the unemployment and economic fallout from Covid-19 would make it increasingly likely that "racial and ethnic minority groups" would experience eviction, homelessness, and/or greater concentration and sharing of housing. Exacerbating this vulnerability was the formal exclusion of noncitizens from the direct economic stimulus distributed by the United States government, which was intended to encourage compliance with lockdown measures and to provide an economic cushion. Even U.S. citizen spouses of noncitizens were excluded from the first round of stimulus payments (see Pérez 2021).

Also aggravating these negative health outcomes is the fact that, as a group, recent immigrants and noncitizens in the United States have substantially reduced access to health care. This is for several reasons. First, many persons without a lawful visa or work authorization—or persons who live in a

household with others who lack lawful immigration status—tend to keep a low profile and, relatedly, are less likely to seek medical attention when sick (Potochnick et al. 2017; Koball et al. 2015). Second, under the Affordable Care Act system, undocumented persons are excluded from access to health insurance subsidies, while many migrant workers and others working as day laborers or on temporary work contracts also do not receive insurance through their employer. Third, although its alignment with the pandemic was coincidental, in February 2020, the Trump administration altered the implementation of U.S. immigration law (8 U.S.C. § 1182) through a provision that holds that "aliens are inadmissible to the United States if they are unable to care for themselves without becoming public charges." The specific rule changes involved expanding the definition of "public charge" to include those who access government benefits like Medicaid, the Supplemental Nutritional Assistance Program, or the Children's Health Insurance Program. This meant that any noncitizen who took advantage of any of these programs, even if on behalf of an eligible minor child, could be prevented from renewing their visa, obtaining permanent residence, or naturalizing as a citizen. After the outbreak of Covid-19, the administration did suspend the application of this rule to healthcare associated with the pandemic. However, the policy still inflicted considerable damage, imposing a chilling effect precisely at a time when peoples' willingness and ability to access medical screening and health care was most critical (Page et al. 2020). Contributing to the issues identified above, myriad other routine barriers reduce the ability of noncitizens to access necessary medical screening and health care (see, for example, Joselow 2020; National Immigration Forum 2020). These include the failure of many low-wage jobs to provide sick leave; barriers of language; and logistical constraints, such as when, early in the pandemic, many U.S. states instituted mass testing sites that could be accessed only by using an automobile (making them unavailable to pedestrians or anyone reliant on public transportation).

The above conditions significantly increased the exposure of noncitizen populations in the United States to Covid-19. Similar patterns have been observed globally, including among temporary farmworkers in Canada (many of whom are also from Mexico and elsewhere in Latin America – see Migrant Workers Alliance for Change 2020; Newton 2020); and in Singapore and the Gulf states, where outbreaks in temporary worker camps drove new waves of infection (Han 2020). In each of these examples, employers "ignored protection measures, forcing migrant workers to continue working in overcrowded conditions and share living quarters with no sanitation"; and yet, these same actors "swiftly tried to blame the migrant employees' poor hygiene practices rather their unsafe working conditions" for the failure to prevent infection (Stop Wapenhandel and Transnational Institute 2020: 5).

Identification of the structural and physical conditions driving increased rates of infection among such migrant, temporary, undocumented, and noncitizen populations brings us to our central provocation: that rather than controlling viral spread via the limitation of human mobility, a more important way that border controls have shaped and intersected with the Covid-19 pandemic is through their contribution to the imposition and policing of unequal legal and political status. These controls have ultimately proved counterproductive when it comes to protecting public health.

Migration and Nation-State Border Controls in the Era of Covid-19

Geographers, among others, have long understood that nation-state borders function not so much as a hard separation or barrier between one population and another, but as a filter and sorting mechanism that allows some persons and bodies to pass through with ease, while others are forced to contend with substantial hardship as they attempt to travel from one country to another (Yuval-Davis et al. 2019; Nevins 2018; Rumford 2008; Sparke 2006; Walters 2006; Hetedtoft 2003). At the same time, as Mezzadra and Neilson (2013) observe, such differences of mobility help define differences of legal and political status that persist long after the moment of border crossing itself, determining the rights, freedoms and privileges that a person is subsequently entitled to exercise. By status, we mean here is the power-laden position that a person occupies within a social system in which resources and

opportunities—be they, for example, economic, legal or ecological—are distributed and accessible on the basis of this position (see Scot and Marshall, 2009). This raises (at least) two issues. First, in addition to being a spatial phenomenon that has increasingly become "mobile," "topological" and/or "polymorphic" (Peña 2021; Burridge et al. 2017; Mountz 2011; Balibar 2004), the border is also essentially a *temporal* one, whereby "the violences and precarities of displacement and migration are structurally created as well as maintained" over time (Walia 2013, 5; see also Boyce 2020). Second, the linear, cartographically demarcated nation-state boundary (with its fantasies of walls, fortresses and territorial separation) often eclipses our imagination of what is at stake in the entrenchment and operationalization of border controls.

Consider: even as governments across the world closed borders to international migrants and travelers, many of the restrictions included gaping carve-outs for national citizens and permanent residents, often without any requirement to quarantine; or, if there were quarantine requirements, they were barely monitored or enforced. For example, when the United States first introduced coronavirus-related restrictions on travel from mainland China in January 2020 (which Trump administration officials continuously touted as a "travel ban"), they allowed U.S. citizens and permanent residents to travel to and from China unencumbered; they also exempted "immediate family of U.S. citizens and permanent residents" (White House 2020; see also Farley 2020). According to one report, almost 40,000 individuals traveling from China arrived in the United States in the two months following the imposition of the Trump administration's travel restrictions, with essentially no public health follow-up (Eder et al. 2020). In March 2020, after the United States expanded this "ban" to countries in Europe, U.S. citizens and permanent residents remained exempt. When the policy was announced, many thousands of persons rushed back to the United States, where they were met not by testing or quarantine procedures, but by lines lasting as long as ten hours in cramped hallways as U.S. officials struggled to manage returning airline passengers (Mintz et al. 2020). This was a perfect environment for rapid viral spread. These passengers then distributed to cities and communities throughout the United States, where many likely seeded new outbreaks. Finally, even as bans on anything other than "essential" travel were extended to the United States' land borders with Mexico and Canada, the definition of "essential" remained highly plastic. At times it exempted U.S. residents and citizens, drivers of trucks registered in Mexico or Canada, agricultural workers, students, business travelers, and recreational tourists with immediate family in the United States. Also noteworthy is that the ban did not apply to those traveling by airplane—in other words, to those with the greatest level of mobility (see, for example, U.S. Mission to Mexico 2021).

More broadly, the ban and the larger regime of immigration control did not put an end to persons entering the United States without authorization—particularly across the U.S.-Mexico boundary. For those tens of thousands who had given up on the formal asylum process, but who nevertheless persisted in trying to enter the United States extra-legally, the ban merely denied them access to judicial review, and, if arrested, allowed for their prompt removal to Mexico through an extrajudicial process that, under Title 42, typically lasted an average of only 96 minutes (Hernández and Miroff 2020). U.S. authorities returned more than 159,000 individuals, including 8,000 unaccompanied children, to Mexico under this policy between March and mid-September 2020 (Ankel 2020). Meanwhile, as Slack and Heyman (2020) discuss, tens of thousands of asylum-seekers who had previously filed an asylum petition in the United States, but whom the U.S. government had previously returned to Mexico, became marooned in northern Mexican border cities. Many were compelled to live in makeshift camps or in densely populated migrant shelters and, after U.S. immigration courts suspended their legal cases indefinitely, these individuals were still required to line up at 4am at US Customs to obtain a new court date at some distant point in the future.

Conditions for noncitizens arrested previously and/or in the interior of the United States and held in long-term immigration custody have remained equally hazardous. For example, immigration detention

centers are by their nature a congregate setting, where large numbers of persons are housed together in proximity, making physical distancing virtually impossible. This situation creates risk for detainees, staff, contractors, and the broader communities through which staff and contractors inevitably circulate. According to one study, US Immigration and Customs Enforcement (ICE) detention activities were tied to an additional 245,581 cases of Covid-19 in the United States between May 1 and August 1, 2020. This was approximately 5.5 percent of all cases recorded in the country during this period (Hooks and Libal 2020). Among other issues, this outcome reflects the failure of those U.S. authorities that oversee the country's immigration detention system to implement basic sanitation recommendations, to make meaningful efforts to allow for the isolation of infected individuals; and to supply its employees, contractors and detainees with adequate testing, screening, PPE, and other basic sanitary supplies (del Bosque and Macdonald 2020; Lippa 2020; Montoya-Galvez 2020; Olivares and Washington 2020).

The continuous introduction of new detainees from communities throughout the United States exacerbated infection rates in ICE facilities. So too did the circulation of detainee populations between the agency's myriad detention facilities, without observing basic testing, social distancing or quarantine procedures at multiple points throughout the transportation process (Stop Wapenhandel and Transnational Institute 2020). Due to this systemic negligence, rates of infection at ICE's detention facilities skyrocketed. By the end of June 2020, more than 50 percent of ICE detainees who were tested for the virus were found to be positive, and as much as 20 percent of the total population detained by ICE had already been infected (del Bosque and Macdonald 2020).

If striations of citizenship and visa status mean that border controls often fail to effectively prevent or meaningfully limit transnational mobility and cause myriad harms in the effort to control it, it is also important to recognize how border and immigration policing work to compel cross-border mobility. Indeed, after essentially incubating the virus within its detention facilities, ICE then exported infected persons around the world through the continuation of removal operations. There were at least 351 deportation flights to 15 countries in Latin America and the Caribbean between February 3 and June 24, 2020, with additional flights to countries including India and Liberia (Johnston 2020). In April 2020, Guatemala's public health ministry reported that 71 of the 76 individuals on just one such flight had tested positive for Covid-19, and that collectively deportees from the United States accounted directly for approximately 20 percent of the country's total number of cases (Finnegan 2020).

To summarize, if the risk of Covid-19 spread is aggravated through, first, gathering large numbers of human beings into proximity for prolonged periods of time, sharing the same air and circulating the virus amongst one another; and then, second, these same persons carrying the virus into new spaces and communities, then the United States border control apparatus appears to be an almost-perfect machine for ensuring the continuation of viral spread. Of course, these outcomes are not inevitable. Various governments, public health officials and grassroots community initiatives throughout the world have pursued alternative approaches to managing the pandemic, efforts founded in a recognition of mutual interests and interdependency rather than on an entrenchment of border controls. In the conclusion, we briefly consider how the U.S. approach to border controls has been mirrored to varying degrees by other countries, before considering what this alternative set of efforts reveal about collective health and wellbeing.

Conclusion: Cultivating "Common Immunity" Through Solidarity and Cooperation Across Difference

The United States is not unique in using the Covid-19 pandemic as justification to target irregular migrants and asylum-seekers through the amplification of border controls. Take Italy, for example. In April 2020, when the country had one of the world's highest Covid-19 infection rates, and soon after having welcomed a brigade of doctors and nurses from Cuba sent to help in the fight against the pandemic (Acosta 2020), Italy closed its seaports to asylum-seekers and to any humanitarian rescue vessel flying a

foreign flag. Italian authorities justified this move by arguing that "those being rescued could 'include people who have contracted COVID-19'" (Sanchez and Achilli 2020, 4; Tazzioli and Stierl 2021). Countries as diverse as Indonesia, Malaysia, Malta, and South Africa implemented similar policies. Meanwhile, citing the threat of Covid-19, Brazil, Colombia, the Czech Republic, Ecuador, Greece, Latvia, Lithuania, the Netherlands, Poland, Slovakia and Slovenia all deployed military or military police to fortify their external borders against irregular entry (Stop Wapenhandel and Transnational Institute 2020).

Australia also implemented hardline policies, but, because they applied equally (barring a small number of exemptions) to citizens and noncitizens alike, that government's pandemic response provides something of a limit-case for our argument. While multiple persistent outbreaks eventually led Australia's federal government to abandon the objective of maintaining zero community spread (see Miller 2021), until February 2022, Australia's Covid-19-related restrictions barred foreign tourists from entering the country. And prior to October 2021, the restrictions banned Australian citizens from either exiting or arriving in the country unless granted an exemption, provision of which (for those arriving) required a 14-day quarantine period in a hotel (Reuters 2021). In addition, many Australian states and territories, at various moments, restricted travel and entry by each other's denizens (Baker 2021). Still, as of May 2022, more than seven thousand Australians had died of Covid-19 (still one of the lowest per capita mortality rates among high-income countries). Moreover, as Dehm (2020) observes, Australia's implementation of pandemic-related mobility restrictions helped to sharpen internal divisions between citizens and noncitizens, and along racial lines. In doing so, these restrictions strengthened the ideological foundation of Australia's already-harsh regime of border and immigration policing—particularly as directed toward those seeking asylum (see, for example, Boochani 2019; Mountz 2020). Thus, while some have argued that the experience of Australia vindicates a public health argument for the closure of nation-state borders (Puyo 2020; Mao 2021), this case also demonstrates the limitations of trying to control a virus by using territorial borders to seal off a population from the rest of the world.

In contrast to Australia, the United States and the many other examples noted above, various countries and communities have responded to the pandemic by instead weaving relationships of solidarity, care and cooperation in ways that transcend differences of nationality and legal status, thus allowing for a generalized improvement in public health outcomes. The country of Portugal offers a striking example. In March 2020, the Portuguese government temporarily extended full citizenship rights to all noncitizens, including the ability to access medical care, testing, and emergency food, housing and financial assistance (Alberti and Cotavio 2020; Ghazal Aswad 2020). As described one Portuguese public health practitioner, "[t]here is [now] no distinction between being an asylum seeker, a migrant or a Portugal-born citizen" (Da Silva 2020).

Meanwhile, in the Arizona-Sonora region of the U.S.-Mexico borderlands, county and municipal health officials on both sides of the international divide coordinated through the Binational Health and Environmental Council to share PPE, medical equipment (like X-ray machines), and testing infrastructure. They also shared data in order to undertake real-time intervention and tracking of Covid-19 cases across transnational borderlands communities, including among visa-holding temporary agricultural workers in the United States. As Dr. Jill de Zapien, the health director for the University of Arizona's Border, Transborder and Binational Public Health Collaborative Research, explained, "[w]hat we see playing out … is the public health community saying 'Ok, we're in this together. And it's not about you and it's not about me. It's about us together'" (Carranza 2020; see also Rosales et al. 2021).

Still other grassroots and organic initiatives have intervened against the border and immigration control system. For example, in June 2020, residents of the Indonesian village of Lancok, in Aceh province, took matters into their own hands after observing dozens of Rohingya refugees stranded at sea due to the policies of the governments of both Malaysia and Indonesia to turn away asylum-seekers

during the pandemic. The villagers of Lancok first petitioned government authorities to help the refugees. After failing to obtain a timely response, the residents organized their own rescue party, sailing out to the refugees' stranded boat to tow it to shore. After helping 94 asylum-seekers disembark, the villagers then organized the distribution of food and clothing to the refugees and requisitioned a former immigration facility to provide them with temporary lodging. Nasruddin, a village leader, told reporters: "[w]e didn't worry about getting into problems [with the authorities], because we believe that what we did was the right thing" (Ratcliffe and Firdaus 2020).

In the United States, immigrant advocacy groups such as TransQueer Pueblo, Northwest Detention Center Resistance and the Abolish ICE NY-NJ Coalition have worked in solidarity with immigrant detainees who have mobilized to demand their release from government custody during the pandemic (a demand motivated by conditions of overcrowding, a lack of adequate PPE, medical neglect, and retaliatory violence meted out by ICE and its many subcontractors). Detainees have pressured authorities through campaigns of letter-writing, sustained non-cooperation and hunger strikes that have spread across facilities. Outside advocates have played a critical role in supporting these efforts by working across the citizen/noncitizen divide to organize channels of communication and solidarity protests that have included marches, pickets and the blocking and barricading of streets outside of detention facilities (TransQueer Pueblo 2020; Zuluaga 2020).

One of the commonalities expressed across each of the examples cited above is a course of action premised on the recognition of mutual interest and interdependency as a foundational condition of life, and therefore also to the fight against disease. The patterns of solidarity that result challenge and stretch the boundaries of citizenship, while suggesting an alternative set of normative principles for the spatial organization of identity, practice and collective institutions that pivot away from an investment in "microbial xenophobia" and instead toward the realization of what Esposito describes as a condition of "common immunity." Following Esposito (2011), the idea of "common immunity" becomes possible to imagine when we conceive of the biological immune system not as a metaphorical amalgamation of soldiers and border guards (e.g., antibodies and T-cells) protecting the body against hostile foreign invasion, but instead as a site of connection, "an internal resonance chamber… through which difference, as such, engages and traverses us" (Esposito 2011: 18). When mobilized as a collective process, the people involved are bound to undergo continuous change. In this way, argues Ozguc (2020), the idea of "common immunity" provides for an "affirmative ethics" and a "celebration of life-in-difference"—one that stands in marked contrast to those "contemporary border politics that defend our narrowly defined exclusive social imaginaries at the time of current crisis." Similar to how the abolitionist tradition teaches that "genuine security does not result from the elimination of threats but from the presence of collective wellbeing," this project requires "building institutions that foster the social and ecological relationships needed to live dignified lives, rather than reactively identifying groups of people who are seen as threatening" (Kundnani 2021, 5; see also Kaba 2021; Maher 2021).

To expand on this approach could involve building upon the everyday struggles of migrants and citizens to resist and transform shared conditions of precarity and hardship (Boyce et al. 2019; Dadusc 2019; Raimondi 2019; Boyce 2021; Tazzioli 2021); while aligning normatively with demands for "open borders" (Jones 2019), a right to migrate, and a "right to the world" (and with this a right to a just and sustainable share of the earth's bounty—see Nevins, 2017). Also relevant is Massey's (2004) idea of "geographies of responsibility." Here, Massey understands space as a realm of obligations continuously renegotiated through the cultivation of connections, proximate and distant, across space. In this way, space is, or should be, understood and approached as "progressive" and "open," in the sense that it has no territorial essence of the type effectively assumed (and performed) by nation-state border policing regimes. In other words, a space of health for all, of common immunity, cannot rest upon pre-ordained territorial boundaries and binaries of citizenship status. Rather, the social and spatial practices involved

can only emerge through a process of negotiation, one that is inclusive and centered on an assessment of power and a remediation of inequity (Massey 2004).

We see practices of vaccination, mask-wearing and social distancing—among the most effective known tools for combatting Covid-19—as indicative of these principles. After all, independent of whether they align with official government mandates, the nature of these practices required that each of us modify our behavior and separate ourselves from others in order to reduce the risk of viral infection. In the process, behaviors aimed at protecting ourselves and those aimed at protecting others became so intertwined as to become practically inseparable. Of course—and this is our point—there have remained radical differences in peoples' ability to adopt these kinds of interventions. And these differences are based on conditions of material inequality that cannot be meaningfully disentangled from nation-state border controls and their unequal dissemination of status and mobility. Consider, for example, how many governments have lifted entry restrictions only for those international travelers who have been able to become fully vaccinated against Covid-19. As the emergence of the Omicron variant in late 2021, first detected by scientists in South Africa, so painfully illustrated, the maintenance of social and material inequality does great harm both to particular individuals and communities, as well as to public health outcomes generally. Rather than extend the availability of vaccines and other measures to combat viral spread (e.g. by lifting World Trade Organization intellectual property protections on newly developed mRNA vaccines and by sharing information on their technical means of production), the most urgent and immediate action taken by dozens of countries in the Global North in response to the emergence of Omicron was to once again impose new border closures (Mallapaty 2021). This episode illustrates the stubborn persistence of public health responses that focus on the control of nation-state borders, despite these being demonstrably short-sighted and counterproductive. Reflecting on these shortcomings should lead to the exploration and enactment of approaches to pandemic disease that are premised on a recognition of mutual interest and interdependency, and on a corresponding cultivation of solidarity, care and cooperation that transcends—and that might ultimately disrupt and abolish—differences of nationality and citizenship status, as well as their territorial expressions.

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